

the
UNIVERSITY
of
TORONTO
MEDICAL
JOURNAL



JANUARY 1971 VOL. XLVIII NO. 3

FAMILY MEDICINE & SOCIAL
PSYCHIATRY

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UNIVERSITY
of
TORONTO
MEDICAL
JOURNAL

Established December 1923
An Undergraduate Publication

Volume XLVIII
Number 3
January 1971

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This Journal is published five times a year from November to March, by the Medical Society of the University of Toronto, to serve primarily as a medium for student expression.

SUBSCRIPTION RATES: \$5.00 for one volume of five consecutive issues. Single copy, \$1.00.

CORRESPONDENCE should be addressed to:

U. of T. Medical Journal,
Room 2141, Medical Sciences Bldg.,
University of Toronto,
Toronto 5, Canada.

Authorized as second class mail by the Post Office Department, Ottawa, and for payment of postage in cash.
Printers: Maple Leaf Press, Toronto, Ontario.

Guest Editorial

DR. JOHN HAY was born in Quebec City in 1920 and obtained his M.D.C.M. from McGill in 1945. Having completed a junior internship at the Royal Victoria Hospital he spent one year as a resident in Pathology at the Queen Elizabeth Hospital and one and a half years as a Staff Physician at the Verdun Protestant Hospital.

He was in General Practice in Pointe Claire, Quebec from 1949-1968 interrupted only by a seven-month period as a Fellow in Internal Medicine at the Lahey Clinic in Boston. From 1965-1968 he was Chief of the Department of Family Medicine at the Lakeshore General Hospital in Pointe Claire.

At present Dr. Hay is the Chairman of the Department of Family Medicine at McMaster University. He is an Honorary Consultant in General Practice at the Lachine General Hospital in Lachine, Quebec and Active Consultant in the Department of General Practice at St. Joseph's Hospital in Hamilton. He is also an Associate Physician in the Department of General Practice at the Hamilton Civic Hospitals.

Dr. Hay has received his certification in Family Medicine from the College of Family Physicians of Canada and has been very active in this body, having been a member of the Examinations Committee and the Undergraduate Education Committee of the College of Family Physicians.



JOHN HAY, M.D.
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Family Medicine - A New Specialty

In 1881, at its 14th Annual Meeting, the Council of the Canadian Medical Association passed the following resolution:

“WHEREAS, The system of specialism and specialists which at present obtains to a certain extent in the Dominion and which has developed to very large proportions in the neighbouring republic, is for the most part the outgrowth of superficial professional education and a want of success as practitioners of medicine and surgery:

THEREFORE BE IT RESOLVED, That it is the opinion of this Society that specialism should be discountenanced by the members of the Society, and that, except in the rare cases where long experience, extended study and peculiar aptitude have placed a man in a special position toward his brethren, specialists should be treated and looked upon as irregular practitioners.”¹

Since this resolution was written, “superficial professional education” has undergone some remarkable changes, and it is interesting to speculate on the reactions of the authors of the resolution were they to be reincarnated to-day. “Specialism” has developed to an incredible degree and the process is unlikely to slacken in the foreseeable future.

The reasons for the development of specialization are not hard to understand, and its advantages are recognized, but by the very nature of the process, each specialty has developed around clearly defined categories of bio-medical problems. These problems may be related to age or sex, as in pediatrics and obstetrics, or to organ systems, as in dermatology and gastroenterology, but an integrated body of knowledge pertaining to the health of the individual and his family, as they exist in society, has not emerged. The component parts, by and large, have been well taken care of, but the whole often sadly neglected.

This situation has been recognized for a long time. Over the years, by default, as it were, responsibility for the care of the individual and his family has been left to the general practitioner, who, at his best rose to meet this challenge and by so doing rightfully earned the respect and trust of the community. He did not however, succeed in clearly defining the discipline within which he practised. The content of a general practice often was, and still is, largely determined by factors that are geographic and socio-economic, or that are related to special aptitudes of the general practitioner, or to the availability of consultant and hospital facilities. These factors pertain to the circumstances in which medical care is given to characteristics of individual physicians and are of limited value in developing a body of knowledge, skills and attitudes that can be recognized as a discipline. Furthermore, the training of these physicians has been quite irrelevant to the work they are called upon to do.

In the face of a critical medical manpower shortage it is vital that the delivery of primary health care be as effective and efficient as possible. Relevant education of physicians responsible for the provisions of primary care thus becomes of paramount importance; it is in response to this need that family medicine has emerged as a new specialty.

In 1964 the Council of Medical Education of the American Medical Association appointed an Ad Hoc Committee on Education for Family Medicine. Two years later the Committee issued a report entitled *Meeting the Challenge of Family Practice*, commonly known as the Willard Report, after the chairman of the Committee, William R. Willard.² In the Report the Committee attempts a definition of the Family Physician, which is, verbatim, as follows:

"The family physician is one who: 1) serves as the physician of first contact with the patient and provides a means of entry into the health care system; 2) evaluates the patient's total health needs, provides personal medical needs within one or more fields of medicine, and refers the patient when indicated to appropriate services of care while preserving the continuity of his care; 3) assumes responsibility for the patient's comprehensive and continuous health care and acts as leader or co-ordinator of the team that provides health services; 4) accepts responsibility for the patient's total health care within the context of his environment, including the community and the family or comparable social unit."

This definition has to do with various functions of the family physician, patient care functions, co-ordinating functions and community functions — but only by implication touches on the field of knowledge, or the discipline, within which the family physician practises.

Many, many words have been written in attempts to define family medicine and the family physician. For example, Lynn Carmichael, of the University of Miami, defines family medicine as that branch of health science whose responsibility is health maintenance of the family. The Committee on Educational Objectives of the College of Family Physicians of Canada states that a certified family physician is one "who is trained to provide primary, continuing and comprehensive medical care to any and all members of the family, using the available ancillary and consultant services to insure exemplary medical care." These and other definitions are stated in terms of function or role; they do not touch on the other vital component of any discipline — the field of knowledge.

The explosion of knowledge within traditional disciplines has made the idea of general practice somehow irrelevant. The question, "How can one man hope to remain competent within all these fields?", is entirely appropriate. The general practitioner has had difficulty in identifying himself with a discipline that can be recognized as such. He leads a professional life in which he has a role but no clearly defined and accepted body of knowledge and skills within which he can function. The sum of the individual components of traditional training has not created a physician prepared to provide effective and comprehensive care.

On the assumption that there should be a close relationship between the training of physicians and their patient care activities, A. H. McFarlane of McMaster University has constructed a model to represent the demands of practice on the fund of knowledge from which the physician operates.³ The data for this model were drawn from 8,000 consecutive complaints and 10,000 consecutive diagnoses over a one-year period in the Department of Family Medicine at the McMaster University Clinic. The frequency of office contacts for each physician, as identified by diagnosis, was retrieved from a computer-based file. These diagnoses were then grouped into disease categories based on the International Classification of Diseases, adapted and arranged in a schematic way to demonstrate the proportional frequency with which diagnoses in each category occurred. Very briefly, the results showed that 51% of the "demands for care" were related to diseases of the respiratory system, the circulatory system and to mental, psycho-neurotic and personality disorders. A further 28% were related to diseases of the genito-urinary system, metabolic diseases, diseases of the skin and cellular tissue and of the digestive system. Diseases of injury of the locomotor system, of special sense organs and of the endocrine system accounted for the remainder.

We believe there should be a close relationship between the size of these diagnostic categories and the extent to which the physician is trained to deal with problems in these categories. We believe that this sort of information, gathered from many sources, can and should be used as one method of defining the body of knowledge and skills that make up the new specialty of family medicine. Without such definition, it is hard to see how appropriate training programs in family medicine can be established and therefore how effective family physicians can be made available to the community.

GUEST EDITORIAL

Departments of Family Medicine have been established and are in operation at seven Canadian medical schools. Certification examinations have been instituted in a number of countries, including Canada, the United States, Great Britain and Australia, the first such examination in Canada having been held at McMaster University under the auspices of the College of Family Physicians of Canada in 1969. In response to an obvious need, Family Medicine is beginning to emerge as a new specialty.

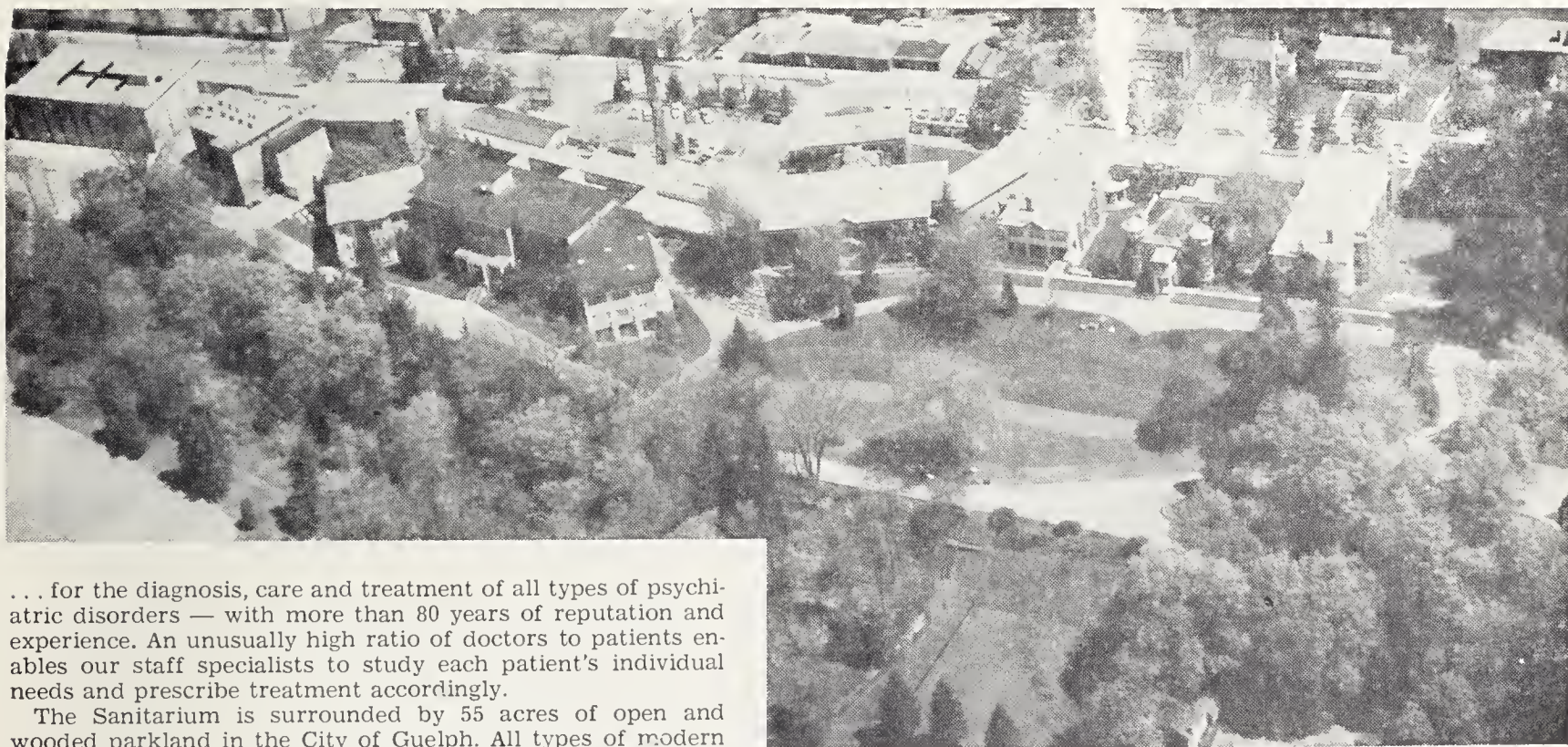
One can speculate that the authors of the 1881 resolution condemning the trend towards specialization somehow sensed that one of the results of specialization would surely be a fragmentation of the care of the patient and his family, and that in this fragmentation something vital would be lost. It is not unreasonable to suppose that these men were aware of an obligation to protect this vital something as an integral part of the practice of medicine. If this was their concern, it is an irony that 90 years later we are using the means they deplored to reach the end they desired.

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Therapeutic Abortion

Titus Owolabi, TT1

The most talked about topics in the delivery of medical care today are medical education, socialized medicine, drug abuse, euthanasia and therapeutic abortion. The last named is probably the most emotionally charged theme for physicians and laymen alike. The issue is further complicated in Canada by a law which is ambiguous with respect to therapeutic abortion. The physician's legally permissible role must be sought through a maze of conditional exceptions.

THE LAW

Devoid of judicial and parliamentary *legalese*, Section 237 of the Criminal Code of Canada implies that a licensed physician may "procure the miscarriage" of a consenting female patient within the four walls of an approved or accredited hospital if two conditions are satisfied. The first requires the therapeutic abortion committee of the hospital to consider the patient's case and decide by simple majority that the continuation of her pregnancy would endanger the life (or health) of the patient. The second forbids the doctor who performs an abortion to sit on the particular committee that approves the abortion. Violation of this law is punishable by life imprisonment of the abortionist. A woman who aborts herself by instrumentation, manipulation, or by the use of drugs or noxious substances is liable to get a two-year prison term.

Furthermore, according to Section 209 of the same code,

(1) *Every one who causes the death, in the act of birth, of any child that has not become a human being, in such a manner that, if the child were a human being, he would be guilty of murder, is guilty of an indictable offence and is liable to imprisonment for life.*

(2) *This section does not apply to a person who by means that, in good faith, he considers necessary to preserve the life of the mother of the child, causes the death of such child.*

Legal authorities conclude¹ that provided the requirements are met as set out by the rather extensive Section 237, "life" means "life or health" and the word "health" incorporates mental and physical well-being. This opinion is based primarily upon the celebrated Bourne case in England in 1938*, and the British Abortion Act of 1967.

* Rex v. Bourne, 1938, involved a girl who was raped. Mr. Bourne consulted with a fellow physician, aborted the girl (illegally in the Britain of 1938), then insisted that he be prosecuted for the abortion. The presiding judge returned a verdict of not guilty. He declared that if pregnancy was likely to make a woman a physical or mental wreck, the physician who aborted the woman did so in good faith and was preserving the life of the woman.

Lawyers point out the vagueness of the term "miscarriage" — there is no definition of a fixed time limit after conception although twenty weeks gestation is the usually accepted limit. The legal term "procuring a miscarriage" is defined as the act of destroying or prematurely bringing forth the foetus or unborn offspring of a pregnant woman at any time before normal childbirth.

At a large university teaching hospital in Toronto, the therapeutic abortion committee³ consists of at least three qualified medical practitioners, comprising one member of the active staff of the departments of Psychiatry, Family and Community Medicine plus members of the active staff of the department of Obstetrics and Gynaecology present at its meetings.

Members meet in the hospital as often as necessary upon 24 hours notice, to consider applications from physicians on behalf of their patients requesting therapeutic abortions. A majority opinion is reached on whether or not the continuation of pregnancy is likely to endanger the life or health of the patient and the decision communicated to her physician.

A physician who applies for a certificate permitting him to perform a therapeutic abortion is not allowed to sit on the particular committee considering his patient's case. He *may* be invited to the meeting but cannot vote.

The constitution and *modus operandi* of this committee follows the letter of the law and are representative of most therapeutic abortion committees in hospitals accredited for such purposes by the provincial departments of health in Canada.

WHO NEEDS ABORTION?

Therapeutic abortion is recommended for a variety of factors which have as a common denominator the preservation of the life or health of the mother. In general, the justification for describing an abortion as therapeutic can be placed in two broad categories.

INDICATIONS FOR T.A. — Group 1: Clear Cut.

Maternal Disease:

Severe Heart Disease

— Heart Failure in Previous Pregnancies

— Heart Failure, recurrent in grand multiparity

Severe Hypertension (toxaemia of Pregnancy)

Severe Diabetes

Severe Kidney Disease

Malignant Neoplasm, activated by pregnancy e.g. Carcinoma of the breast

THERAPEUTIC ABORTION

Embryopathies

- Infections (rubella)
- Chemotoxic (thalidomide)

Diseases Transmitted to the Foetus

- Genetic
- Environmental eg. multiple trauma to gravid uterus

Improved methods of prevention and management of diseases in these so called "purely medical" indications for therapeutic abortion have resulted in a gradual decline in these cases over the years. When these cases do arise and are considered for abortion, a morally acceptable decision is not too difficult to reach. Chances are the patient has received adequate ante-natal care. Chances are she wants to carry the pregnancy to term. She probably *accepts* abortion as the best course to safeguarding her health and life only because she has been so advised by a competent obstetrician. All but the ultra-ardent anti-abortionists now seem persuaded that relieving such a woman of her pregnancy is not only ethically acceptable, but also morally indicated.

In a study of the subjective emotional reaction of women to therapeutic abortion, McCoy concluded that such patients whose pregnancies are terminated for "purely medical" reasons have a high initial rate of regret but subsequently adjust well and accept the situation as satisfactory.

GROUP II — CONTROVERSIAL

Mental Health

Schizo-Affective Gestational Psychosis

- Schizophrenia 50%
- Depressive 40%
- Toxic delirious 10%

Reactive Depression $\pm$ Suicidal Intent

- Neurotic
- Prepsychotic
- Psychotic

Humanitarian and Eugenic

- Rape
- Incest
- Mental Retardation

Social and Community

- Unwanted Pregnancy (Innumerable Reasons)

Except for the humanitarian and eugenic reasons, the rest of this group constitutes the bulk of the so-called "psychiatric indications" for therapeutic abortion.

Twelve years ago, Cappon stated ". . . there is no absolute indication for therapeutic termination of pregnancy other than the comparatively rare syndrome (schizoaffective gestational psychosis) in which pregnancy *per se* plays a major aetiological role"⁵. Yet of the total of 262 therapeutic abortions done at the Toronto General Hospital from 1954-65, psychiatric indications were the single most common type.⁶ The following figures were reported:

Psychiatric	90 (34.4%)
Rubella	41
CVS Disease	28
Others:	Renal
	CNS Disease
	Diabetes 101
	Malignancies, etc.

From April 1965 to April 1966, 11 therapeutic abortions were done at the Toronto Western Hospital⁷. The breakdown of the indications is as follows: Psychiatric (6), Neurological (3) and Rubella (2). There are as yet no figures available on the number of therapeutic abortions done annually in "accredited" hospitals since the advent of the therapeutic abortion committee. Undoubtedly, the number must be impressive and a very high percentage would be done for psychiatric reasons. In a Tampa, Florida, study where a T.A. committee existed when the study was undertaken the statistics were:

Psychiatric Indications	77.5%
Medical Indications	16.3%
Foetal Indications	6.2%

The point is that mental health now constitutes the foremost reason for therapeutic abortions. The average patient is a young woman with no organic disease who gradually "realizes" she is pregnant and finds this socially or psychologically unacceptable. In her desperation, various psychodynamic processes interplay. Ego decompensation may or may not occur. The patient consults her physician and asks to be aborted.

Translated into terms of medical personnel and facilities the "accredited hospital" clause dictates that the woman see a gynaecologist (who may or may not be the first contact physician) and often a psychiatrist as well. Depending on the clinical, and hopefully total situation of the patient, her case may be presented to the local committee legally empowered to settle her case.

THE PITFALLS

The implications of the process are immediately obvious.

1. There are bound to be differences of untenable proportions in the criteria used by the different committees. (Witness "liberal" versus "conservative" hospitals, often within the same city.) These committees are panels of doctors deciding the therapeutic efficacy of a surgical procedure: this system would seem too sensitive to individual moral values to be satisfactory.

2. The middle and upper socio-economic classes are distinctly favoured. By virtue of superior awareness of what to do and how to do it, a woman in a higher income bracket is more likely to convince her "private gynaecologist" to relieve her of an unwanted pregnancy.

Ironically if the committee says no, this woman can afford a "vacation deal" to Mexico, Britain, Japan or New York State, and get an abortion. The situation is not so easy for a woman in the lower socio-economic group. Many of these women get pregnant in the first place because of ignorance in the use of adequate contraception. Some do not seek medical help for therapeutic abortion at all. Some will be presented to the T.A. committee but will not meet the medical-psychiatric criteria of the particular committee. Some of these women have resolved to obtain an abortion and resort to illegal and dangerous means to get it. Many a physician will remember cases of septic abortion brought into the hospital Emergency in the darkest hours just before dawn.

3. A judicial-type system has been evolved to handle a purely medical problem. Consider the various ways of terminating a pregnancy:

Dilation and Curettage (D&C)	<	Suction Scrapping.
Artificial Rupture of the Membranes (ARM)		
Abdominal Hysterotomy		
IntraAmniotic Injection of Hypertonic Saline		
Fundectomy		

These procedures, like any medical or surgical treatment, have associated risks⁹.

A Mortality	6/100,000	therapeutic abortions
B Morbidity		
Early		Late
(1) Haemorrhage — Anaemia	(1) Psychological reaction 25-59%	
(2) Anaesthetic risk	(2) Menstrual Irregularities	
(3) Thrombophlebitis	(3) Sterility	
(4) Fistula formation	(4) Chronic PID	
(5) Perforation of the Uterus	(5) Risk of Ectopics	
(6) Sepsis and Shock		
(7) Air Embolism		

The point here is that therapeutic abortion is a medical problem which should be treated as such. Social legislation may have its place in the handling of a vexing problem which is as loaded with religious, social, moral and ethical values as abortion is. However, when an abortion is THERAPEUTIC, it is a strictly medical problem. Politicians and judicial experts may make relevant laws but the law should be so formulated that physicians can handle every individual therapeutic abortion as a clinical entity, not a legal problem.

At its annual convention in Winnipeg last June, the Canadian Psychiatric Association offered a solution: remove therapeutic abortion from the Criminal Code entirely.

4. The Doctor-Patient Relationship is distorted. To stipulate that the physician who will perform a thera-

peutic abortion should not sit on the committee reviewing the particular case is to remove from the adjudicating committee perhaps the one doctor who has first-hand information about the patient. The decision to carry or terminate a pregnancy is made by a committee that probably never saw the patient. This *prescriptio in absentia* is not only poor medicine, but also is unfair to the patient.

CONCLUSION

It is to be hoped that soon, the days of the therapeutic abortion committee will be numbered. Whether T.A. belongs on the Criminal Code is open to discussion. The arguments in support of the stand taken by the Canadian Psychiatric Association are convincing.¹⁰

It seems reasonable that the opinion of two physicians should be valid enough to decide the role of abortion in the therapeutic regimen of a pregnant woman with organic or psychiatric problems. One of the two medical practitioners *should* be the patient's first contact physician — be he a gynaecologist or a family doctor. The first contact physician should familiarize himself with the patient's situational problems. For very often an unwanted pregnancy is only part of a psychological symptom-complex, and an abortion will produce symptomatic relief not cure. In this respect, the services of the often neglected paramedical personnel are invaluable. Nurses, psychologists, social workers working with medical practitioners can gather an armamentarium of information that could effectively define the interactions of a particular pregnancy on a woman's health. If abortion is decidedly therapeutic, no law should stand between the woman and an intervention of her pregnancy.

This is not to advocate abortion on demand. It is equally untenable to argue that a woman can rightfully expect to be aborted of a pregnancy simply for the asking.

The question of "ultra-liberal" and unscrupulously motivated doctors does arise. Hopefully, the latter are few and far between. Faulty judgements by a doctor are again the exception rather than the rule. Every doctor who pronounces a particular abortion therapeutic and proceeds with the intervention carries on his conscience the consequences of his actions. Medical health delivery is effective only when the physician shows genuine concern for the patient and the latter has confidence in the judgement and ability of the doctor. To argue that a more readily obtained abortion will result in no scruples and lowered moral values is to deny these facts and to propagate undue hardships on present and future generations.

NOTE

(1) Due gratitude is expressed to Dr. F. R. Papsin of the Department of Obstetrics and Gynaecology, U. of

T., and the Toronto Western Hospital for making available some of the resource material referred to in this article.

(2) Opinions expressed in this article are those of the editor and do not in any way reflect the views of the U. of T. Medical Society or Faculty of Medicine.

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Organizing A General Practice

L. S. Erlin

In this article, suggestions are made on some key points in arranging a family practice office. It is by no means complete and by no means ideal for every general practitioner. It has been composed from journal articles as well as from suggestions of various doctors in practice. It is hoped that most of the important points are adequately emphasized.

OFFICE LAYOUT

First and foremost is the design of the office layout. It is designed from the point of view of both efficiency and appeal to the patient. The diagram shown is supposed to represent a good functional result.

Turning to the *WAITING AREA* first, for even with the most efficient appointment system, it is likely that the majority of patients will spend their time in the waiting room. I quote from reference 1. "Any patient who has spent an hour in a stuffy, ill-lit room, surrounded by coughing, sniffing patients, alternately fidgeting with wet clothing and eyeing each other aggressively to see who might be trying to get in to the doctor early is not going to reach the consulting room in a relaxed frame of mind. Any mother who has to try to control a boisterous toddler and keep the baby quiet in a room full of elderly, fractious patients may well arrive harassed and embarrassed."

The plan is based on a one-man practice with a receptionist-nurse in attendance. The unit has been broken down into various subdivisions as follows:

1. The main Entry and Reception Area..The reception area or desk should be placed in a position where there exists the best control of entry and exit to the various areas in the office, i.e. waiting or consulting room, and should also afford an easy means of overlooking the waiting area.

A key consideration is whether or not there is enough space to control influx of patients without impeding circulation of the whole unit. It is suggested to allow about 30 sq. feet, enough for 4-5 people as the possibility of large groups arriving at the same time cannot be overlooked.

Is it possible to carry on a conversation with the patients without the whole waiting room hearing? Ideally, the receptionist should have an area of her own.

2. The size or space standards are affected by the type of practice. Certain considerations would be: do patients come by appointment system or attend on a casual basis when ill? What is the average length of consultation plus the time for the next patient to reach

the room? What is the pattern of transport? If it is by infrequent public transportation patients may often arrive in large groups at irregular intervals. The following are suggested:

- a. Visits by appointment —
 - for one doctor at least 7 seats
 - for two doctors 6 seats / member
 - for three or more 5 seats / member
- b. no appointments needed —
 - 1 seat / 200 urban population
 - 1 seat / 200 rural population

In all cases, an area of 10 sq. feet per person is considered adequate with circulating space taken into account. As to cross infection from communicable diseases, it is suggested that seats facing each other be at least 6 feet apart.

3. The environment must be considered under the points of comfort, assurance and diversions while waiting: can furniture be arranged to take best advantage of views and sunlight? Do windows overlook street or surrounding buildings? If so, screening by drapes or venetian blinds is necessary.

If patients will be keeping their outside clothes on, the heating should be set at about 60-65°F instead of the normal 65-70°F in other areas. For safety reasons it is best to avoid radiant or high temperature surfaces as well as electrical outlets where children can reach them.

The sick and elderly are sensitively aware of glare from the lighting. Such could be caused by sunlight coming through an unscreened window, bright lights by the seating area, etc. Where possible chairs should be at right angles to windows. It is advisable to maintain overall levels of lighting at about 15 lumens with lamps for reading in part of the seating area if patients will be waiting a long time and reading.

4. The furniture layout must be functional. It is best to break areas down to small groups of 4-6 persons. This provides a more relaxed, informal atmosphere and permits segregation of young and old, well babies and the ill. If separate areas for mother and young children could be provided, this would remove a source of noise and embarrassment. Ideally there should be a separate area with nursery furniture and toys for children to play.

The type of seating is also important. Do you use chairs with or without arms or unit bench seats? The disadvantages of chairs are that they tend to become disarranged, they may look untidy, they may be unsteady (elderly patients!) and they can't be integrated into a design pattern with tables and magazine racks as easily as a unit seat. They also tend to mark walls. Their advantages are that they can be moved easily and can be stacked if necessary, various types of chairs can be provided for different patients, i.e. elderly vs young, and they are usually cheaper than the unit bench.

5. Next is the finishing on the walls and floors. One must be able to clean i.e. wash down or redecorate with minimal expense and time. Ideally, walls should be covered in washable wallpaper or a good quality paint.

The floor should be non-slip, hardwearing, and easy to clean. If tile is used, one avoids very dark or very light colours as both require constant cleaning. Carpeting, with some reservations, should be of commercial and not domestic quality. It should have a pattern as stains show less easily, and it should be coloured in a shade that does not show stains easily. If carpets are used they should be fitted and secured for obvious reasons.

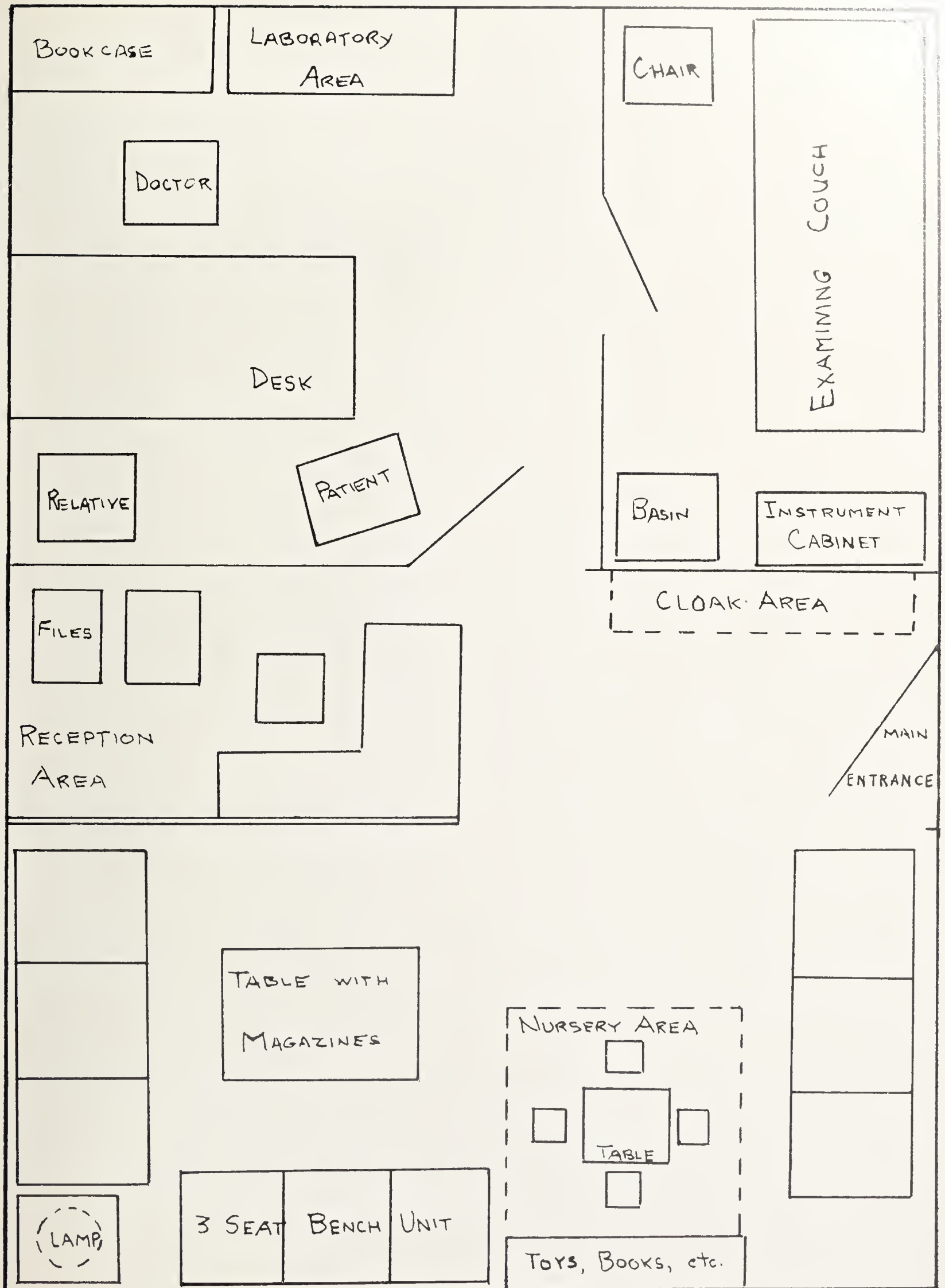
Next to be considered is the consulting room. The main purpose is to use it efficiently and conveniently. Basic assumptions are that it is 10' x 12', the examination room is off and adjoining the consulting room, and the receptionist, office records and files are outside the consulting room.

In terms of function, the following are approximate estimates of the time allocated to various activities in the office. About 15% for patients who will have local examinations while seated, about another 15-20% of the time for patients needing thorough examinations in the examining room and the rest of the time will be involved with history taking, giving advice and counselling, writing prescriptions, and filling out billing forms and certificates.

There are several considerations to the layout of the office. The doctor must see the patient clearly as he enters the room. He must be able to look without moving his chair and see the patient's face in good light. Likewise, the patient should see the doctor clearly as it is unnerving to meet anyone who is silhouetted against a bright window and whose face is in a shadow. The patient's route to the chair should be short, direct, and obvious. The window should be obscured to ensure privacy and also to reassure the patient of this fact. The doctor's chair should swivel and he should be able to reach documents and equipment from his position at his desk. The room is badly planned if the doctor has to get up and walk across or behind the patient to get some item which he frequently needs. The consulting room must have good sound insulation from the waiting-room and also from the traffic outside. Natural light is not essential but if available from the direction of the patient's feet would be an asset in the examining room.

The impression of furnishings, finishings and decorations on the patient's mind can be important for putting him at ease. Strong colours on walls are unadvisable because of distorted light reflections. It is important to have bright curtains and comfortable chairs. The doctor feels at home in the office he furnishes to his personal taste but the patient is only affected by the immediate impression on first seeing it and it is important this impression be favourable.

ORGANIZING A GENERAL PRACTICE



FLOOR PLAN

APPROX. 450 SQ. FT.

Now looking at the sample office design shown, it can be seen that several key points have been incorporated into it. The reception and filing area has been used as a separation between office and waiting room serving the dual purposes of (1) controlling entrance to the office as a whole and the consulting room and (2) providing privacy for quiet conversation in the consulting room. The bench units have been placed along the periphery of the room in 4-6 seat units with a magazine area in the centre. This layout also utilizes space to its utmost so that when one considers the rental costs per square foot money is saved. Turning to the doctor's office there exist three functional areas. One is the doctor's area where he can carry on conversations, write prescriptions, notes, etc. and carry out simple laboratory and diagnostic tests (urinalysis, etc., etc.) if he designs his practice as such. Secondly, the patient area is separate and obvious in the layout. The third is the examining area with a basin and utility wagon. All are separate and are accessible directly and easily from all other areas.

The last consideration is the number of paramedical personnel. The plan in this article involves only one examining room, partly because of the desire to reduce overhead rental costs and also because the plan was based on there being only one assistant. Whether to have a receptionist or a nurse or both will depend on the volume of the practice, the laboratory tests done in the office and the earnings of the practice. If the nurse is to do the minor tests such as urinalysis, haemoglobin, and take basic measurements of blood pressure, pulse, temperature, etc., clean the examining room after each patient and tidy up, assist when necessary in the examining room and have the records of the next patient on the doctor's desk before he is seated, then her time may be fully involved in this. A second girl may be required to make appointments and interview patients to get basic information as to insurance, age, place of work and residence, and even a history of any hereditary or family illnesses, etc. If billing is to be done directly to the patient as opposed to the government and the practice is busy, then two assistants are probably required. It may actually pay to have two as the doctor's efficiency in being able to see more patients in a given space of time will probably increase more than the additional salary cost.

What is the expected cost of setting up and then maintaining such a practice.

The following cost of setting up a practice is based on urban conditions and represents a minimum.

COST OF SETTING UP A GENERAL PRACTICE

<i>Receptionary</i> —2 filing cabinets, desk, 2 chairs, typewriter, dictaphone, small items	\$1250.00
<i>Waiting Area</i> — Bench Units, Tables, Lamps	1500.00
<i>Doctor's Office</i> — Desk, Chairs (3), Book Case, Lamps, Pens, etc.	2000.00
<i>Examining Room</i> — Couch, cabinets, instruments	3000.00
<i>General</i> —Drapes, Braodloom, Wall coverings	1800.00
TOTAL	\$9550.00

COST OF MAINTAINING A GENERAL PRACTICE

<i>Office Costs</i>	
Receptionist Salary	\$ 4500.00
Nurse's Salary	5500.00
Rental 450 sq. ft. at \$8.00 per sq. ft.	3600.00
Insurance	500.00
Laundry	200.00
Repairs to equipment	100.00
Depreciation fixtures, furniture (10%)	1000.00
Magazines, flowers	200.00
Telephone (and intercom)	400.00
Answering service	300.00
Bell Boy	360.00
Stationery and Postage	1000.00
Accounting	500.00
<i>Visiting Costs</i>	
Car expenses	1000.00
Car depreciation (25%)	1000.00
<i>Others</i>	
Medical Subscriptions	100.00
Postgraduate Courses including accommodation (min.)	500.00
Total per year	\$20,760.00

We hope this article will be of some help to those who are considering going into general or specialty practice.

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Family Therapy

Richard B. Simons

INTRODUCTION

Family therapy is a relatively new concept in psychiatric circles. It began in the early 1950's with several individual practitioners trying to come to grips with the family as a psychiatric entity. Viewing the family as one would view an individual or a group in psychodynamic terms, has led to the development of several different "schools" of treatment. This article consists of two parts. The first part briefly outlines one method of looking at family psychodynamics and the second part presents a review of the approaches various therapists use.

PART I

FAMILY PSYCHODYNAMICS

The following schema⁷ categorizes areas of family function as an aid in analyzing the psychodynamics of the family.

FAMILY PROBLEM-SOLVING

Family problems may be divided into instrumental problems which are defined in economic, physical or health terms and affective problems. Affective difficulties in turn may have an expressive component, and an involvement component. The ability of a person to respond emotionally with affect that is appropriate defines the expressive component. Involvement refers to the degree to which members of the family become emotionally involved in each other's activities.

COMMUNICATION

Communication may be defined as the medium through which people relate to each other. Family communication may have affective, instrumental, as well as other modes of expression both verbal and non-verbal that result in a pattern of communication for that family which may be quite unique. In the family messages may be aimed directly at the person for whom they are intended or they may be displaced. In disturbed families affective communication is most likely to be disrupted initially followed in more serious cases by disruption of instrumental communication. Non-verbal communication plays a great role in the understanding and treatment of family psychopathology.

ROLE BEHAVIOUR

The mechanism that determines role behaviour in the family may be thought of in psychoanalytic terms as projection. Unconscious images or one's own ideas are ascribed to others. The traditional roles in the family of father, mother and son or daughter and child are defined to some extent by the cultural milieu as well as innate biological endowment. Family members have certain conscious and unconscious expectations that other members will conform to these projected images. The incongruity of many of these expectations with the

actual functioning role of the member in question may have much to do with the psycho-pathology of the family.

AUTONOMY

Autonomy is defined as the capacity of members of the family for independent action. It may also be thought of as the ultimate goal of the child's development.

BEHAVIOUR CONTROL

This is the pattern adopted by the family in handling impulses, maintaining standards of good and bad and dealing with physically dangerous situations. This degree of control ranges from rigid, through flexible, *laissez-faire*, to chaotic.

PSYCHOPATHOLOGY OF THE FAMILY

One concept of family psychopathology is that of an individual not functioning at the optimum of his psychosocial potential and the consequences of this in the family. Assessment of the potential capacity for psychosocial functioning in the dimensions such as those enumerated above is required to evaluate degrees of psychopathology in the family setting. The ideal level of emotional health implies lack of structured psychiatric symptoms, social and occupational adaptation and psychodynamic integration. Psychodynamic integration consists of a structural-functional component that refers to those elements that enter into personality development such as perception, appreciation, cognition, intelligence, and bodily functions. The other area of psychodynamic integration is the psychodynamic motivational component which refers to the unconscious psychic conflict or crisis stages that each individual must deal with during his development, and in the process of everyday living. If these conflicts are being dealt with effectively they do not generate excessive anxiety. Satisfactory functioning, of course, is defined differently at the various levels of human development. Significant family psychopathology usually involves both parents and at least one child. Psychopathological interaction in the family impedes the development of optimal growth and functioning within individual family members.

PART II

FAMILY THERAPY

DEFINITION

Family therapy which developed from individual and group therapies has the following four characteristics.² More than two people are involved so that communication with the physician is not strictly confidential. Non-verbal communication is generally more important than verbal. The membership, seating, gestures, and posturing of family members are observed and may be pointed out or manipulated by the therapist. The sessions are

generally shorter than individual therapy and the total period in therapy is shorter. The therapeutic goal is to change the family system when appropriate and not treat individual psychopathology specifically. One drawback of the method is that the members involved generally have well constructed defences that are difficult to break through and sometimes necessitate relatively superficial psychotherapy compared with individual psychotherapy. Also, it is difficult to simultaneously observe non-verbal communication, interpret its meaning, and act constructively to enlighten the patient or manipulate the situation.

There are two basic divisions in the practice of family therapy: the conductors and the reactors. Conductors, who are generally older more compelling figures, stay on top of the group situation and lead patients to explicit therapeutic goals selected by the therapist for the family. Reactors who tend to be more contemporary with family members respond to the various members of the family and interpret their behaviour in a non-directive way. Their goals are less explicit and their control less overt than conductors. Reactors are divided into analysts and system purists. The prime concern of the analysts is to reveal in psychoanalytic terms the psychodynamic processes of individual members, whereas the system purists are concerned with the psychodynamic networks of countervailing power determining the psychopathology of the family system.

CONDUCTORS

NATHAN ACKERMAN

Ackerman¹ has a unique style of therapy in which he commands the arena from a central position acting in ways which may appear intrusive, insulting, or autocratic to focus quickly on the family's problem areas. He seeks out the primitive relations of sex, aggression, and dependency in the family and breaks down personal defences by establishing rapport with the members of the family. He breaks family taboos, mentions the unmentionable, and points out how they are covering themselves from him by their behaviour. As he stresses the reality of the family situation he probes the members' expectations and perceptions of the situation and assesses the anxiety generated by the gap between expectation and reality. By his own good-humoured open attitudes to the healthy expression of sexuality and limited aggression he gives the family goals to work toward. By concentrating on the non-verbal interaction within the family and between the members and himself, he clears away what he calls the "hypocrisy" of the verbal channel. His skill at manipulating non-verbal communication must be observed to be appreciated and is almost impossible to teach.

VIRGINIA SATIR

Satir¹³ presents herself to the family as a teacher, an expert in family relations who has a sense of direction.

She will teach them a new language to deepen their relationship by increasing true communication.

MURRAY BOWEN

Bowen⁶ takes the model for his therapy of himself as a researcher teaching the family to be researchers. He works by choosing the most mature member of the family. Using the mechanism of transference, he gets the patient to assume certain attitudes towards the therapist and then watches for these attitudes to be transferred to the rest of the family. His art lies in breaking only pathological bonds. The family, after a stormy period, comes to a new equilibrium.

SALVADOR MINUCHIN

Minuchin¹¹ works primarily with poor families who have little impulse control or insight. He calls his form of non-verbal therapy "enactive" or "iconic". He actively breaks patterns of action within the family which results in emotional reactions. Hopefully the end result is a healthier family system. For example, Minuchin selects a mother and daughter in whose relationship a grandmother cannot avoid interfering. He tells the mother and daughter to continue talking while he takes the grandmother behind a one-way screen to observe and tell him her feelings about the other two. Thus, he gets the grandmother to enact her separation from the mother and daughter.

ROLAND THORP

Thorp¹⁴ simplifies family relations into four categories: solidarity, sexuality, external relations and internal instrumentality. After examining the family he sees which areas are chiefly affected and has the family draw up explicit, sometimes written, contracts delegating responsibilities. Expanding from these specific areas the technique of negotiating issues is taught to the family. Self-esteem is engendered in this process as the different members realize their bargaining powers and responsibilities that result from the contracts. With increasing self-esteem maladaptive defences become dysfunctional and disappear.

MIT

Multiple Impact Therapy¹⁰ at the University of Texas in Galveston specializes in families with adolescent problems. The family comes to Galveston for two days of intensive interaction with doctors, social workers, psychologists, ministers, and others. Role differentiation, flexibility, open criticism, and communication are encouraged in individual and combined interviews. This is a very intensive experience which is anhistorical, prescriptive, and future-oriented. The family then returns home and is encouraged to try out what they have learned.

NORMAN PAUL

Paul's therapy¹² shares with analytic theory an emphasis on the parents' relation to the grandparents during early development. Paul feels that there is a ghost-like

parent figure representing one of the parents from the previous generation. This figure must be identified. Much of the psychopathology in the family may stem from unresolved conflicts in the parents' mind concerning one of the grandparents. Paul therefore actively probes to identify "the unmourned parent" and by bringing out early memories and fears attempts to have the patient transfer these emotions to the therapist. At the same time he empathises with the patient and encourages the spouse to empathise as well. Meetings with the three generations are encouraged when possible. Paul sets himself up as the exorcisor of the ghost and dominates the communication pattern.

JOHN E. BELL

Bell wrote one of the first papers in the field of family therapy⁵ and his techniques are to an extent a prototype for the entire field now. He has a definite progression of phases in which he examines family interactions. He usually works with families in which the child is the identified patient. The initial interview is with the parents only. At this time he extracts a promise from them that they will accept some modification of the family's rules at the next interview if suggested by the child. This sets the parents up initially as co-strategists in therapy but, paradoxically, binds them to allowing the child some limited control over the pattern of family relations.

Next, there is a "child-centred phase" wherein the child is encouraged to ventilate his fears and grievances. The "parent-child interaction" follows and leads to a familiar family stalemate. Bell then brings out an interpretation of the problem which usually points out that the family difficulties are primarily between the parents. This leads into the "father-mother interaction" where the major difficulties of the whole family are often brought out. Therapy continues from here to support and interpret the parents' situation so that they eventually decide to do something differently. The end result is hopefully a discovery of the parents' potentialities in each other for the resolution of their difficulties.

REACTOR-ANALYSTS

Carl Whitaker's ideas demonstrated two aspects of the reactor type of therapy. The psychoanalytic tradition of searching for a non-rational, unconscious truth which must be uncovered before the patient can be truly free is generally accepted by the reactors. Also Whitaker feels that the dynamics in the therapy session are so complicated that co-therapists, usually male and female, are necessary. One therapist can objectively observe as the other becomes involved in the dynamics of the family. The therapist by the transference mechanism may be called upon to act out the projected wishes of the family in the role of a parent figure. Whitaker feels the core of his therapy is to become intensely involved with the family in such a relationship and then the co-therapist steps in and presents an interpretation of what is going on. He feels that "the task of psychotherapy is to be

available as a team to move as participants of the psychological and social patterns of the family, and then to aid the family unit in its autopsychological reparative process."¹⁵ Whitaker's involvement with the family may link him with father to help him be dominant, be seductive of mother and make father jealous or organize an overt war between the generations. His use of a co-therapist allows this degree of involvement as well as demonstrating to the family by his own flexibility how rigid their own positions are.

SYSTEM PURISTS

The system purists such as Gerald Zuk, Jay Haley, and Don Jackson are more activist than analysts but they are quite wary of the power of the family to manipulate the therapist. Their leadership of the therapy is covert and at times may seem cynical and disingenuously artful. The theoretical basis of their therapy lies in the communications concept of behaviour. An analogy may be drawn between the family and a chess game. Although the history of preceding moves is important in the game the present positions and how they are played is most important in determining how the game will proceed. The system therapists contend that the internal dynamics of the family situation are too complicated to be explained and instead they focus on the input and output of the system as it functions now.

There are several axioms which are invoked by these behaviour-oriented therapists:

1. *All behaviour is communication.*
2. *Messages have report and command functions.*
3. *Command messages define relationship.* Ambiguity and duplicity are possible in determining these relationships. Also communicants are often unaware of the commands they are giving or receiving.
4. *In families command messages are patterned as rules.* Rules constrain and order behaviour in a system of mutual influence which has cybernetic properties. These rules act as limits of acceptable behaviour in a negative feedback control system in which sanctions are imposed to change behaviour which transgresses the rules.
5. *Changes and stability.* For the system to change the rules must change against a background of homeostatic influences maintaining the *status quo*.
6. *Inability to change rules is system pathology.* Rules may be set in such a way that there is no way of changing them. This happens when two paradoxical rules negate each other — one being an operating rule the other being a rule-about-rules. In such a situation no one can take a position outside the communication (*become meta* to it) and talk *about* it with the intent of changing it.
7. *The family therapist must install himself as the meta-communicator or change-maker of the family.*

Haley⁸ notes several strategies therapists use to establish themselves as the change-maker.

1. A therapist may engage in alternate siding to force the stalemated conflict to resolution.

2. He comments openly on the way he is being influenced thereby breaking the rule of silence and exposing the paradoxical bind.

3. He accents the positive aspects of otherwise conflicting relations.

4. He encourages and labels behaviour which is already going on at the direction of the family's rule-keepers, thus making the momentary leadership of the group explicit and breaking its power.

An example of this strategy in marital therapy is the directive of therapist that a quarrel-prone couple go home and have a fight. The therapist might relabel their fighting by saying that it is a way of gaining an emotional response from each other and they both need that response. He might say that when they begin to feel closer to each other they panic and have a fight. Explanatory insight is not important here, it is the precision of the intervention of relabelling the fighting and thus taking control that counts.

Jackson⁹ finds that merely pointing out the repetitive patterns of pathologic behaviour does little good but he tries to shift the meaning, intent, and focus of this behaviour. He plays down the "sick" aspects of the relations and minimizes his own overt direction of the proceedings. His intervention in the family is the one requirement he makes of them. It has three features: on the surface it appears to be easy to do, secondly on an interpersonal level it shifts the meaning of a symptom or the balance of power and finally, it has "meta" communication value in that it is outside the pathological family system. Some examples of these interventions are:

1. The "well" sibling of a schizophrenic is instructed to be more of a problem to the family. This has the effect of revealing how much of a problem he already is, and changing the "sickness" image of the schizophrenic patient.

2. A family is told to have a fight before they go on vacation so they can enjoy the trip.

3. A delinquent stepson who will not pay attention to his new stepmother is asked to agree that no matter how angry she gets, he will pay no attention to her orders — indeed she is not to give any. He will be disciplined only by the father.

The key note of this therapy might be "prescribe the symptom". By exaggerating the problem it in a sense comes under some therapeutic control.

SUMMARY

Any attempt to present a synthesis of all the disparate views of family therapy reviewed here would be artificial.

However, a few points may be noted. The initial premise of family practice therapy is the view that the family as a system is a contender with the individual-within-the-family for the attention of the therapist. The dichotomy between group and individual argued about so vehemently by analysts and system purists is a false one in the sense that behaviour which is expressive for the individual is communicative for the group. The richness of family therapy in the view of some is seeing the interlocking of the family system and individual psychodynamics.

There are some unifying features common to most of the therapies outlined previously. Most observers agree that the therapist must avoid becoming a regulated part of the family system or he will produce no change. Secondly, the importance of non-verbal communication has been emphasized universally. In their review article⁴ Beels and Ferber state that "... (any) change that is brought about in the family is somehow encoded in a level of communication or perception other than the verbal-abstract. The suggestion is that the family's regulatory system and the experience which is the key to change in that system are embodied in a communication pattern which is only fully developed and clear when the family are in each other's presence".

Although there is no unity in the methods of family therapy, there is unity in the belief that therapy should take place with the entire family in the presence of the therapist.

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INTRODUCTION

Ever since Leo Kanner first described and named the clinical syndrome known as "early infantile autism" in 1943, it has remained one of the most puzzling and fascinating afflictions of childhood. It is a disease with an unknown cause and an unknown cure. What is more, the apparently healthy and intelligent children who are afflicted with the disease present a peculiar combination of genius and idiocy. The mere use of the word "autism" has also presented some problems. The widespread, improper and universal use of the word has contributed to many incorrect diagnoses. Kanner himself contributed to the confusion by his stress on "aleness" and "preservation of sameness" as major aspects of the syndrome without stating that these are necessary but not sufficient evidence for establishing the diagnosis.

Obviously, such a poorly understood disease cannot possibly have a very good prognosis. Generally, the prognosis is unfavorable even with early recognition and treatment. Of the very few cases in the literature that have been "cured", so many symptoms persist that it would be overly optimistic to label them as such.

Besides its poor prognosis, another discouraging aspect of the disease is the fact that it is not as rare as it was once thought to be. It is certainly uncommon, but it is not rare.

SYMPTOMS OF THE DISEASE AND DIAGNOSIS

There are marked variations in the age of onset of the illness. Unlike the original cases described by Kanner with onset during infancy, there are many otherwise typical cases with onset anytime in the first four years of life. Therefore, Kanner's original name "early infantile autism" is not an appropriate label. Wing proposed the use of "Kanner's syndrome" for the "pure" cases with infantile onset and "early childhood autism" for the others. The term "autism" is retained to describe the actively withdrawn behaviour so typical of these children.

Marked variations in the degree of the disturbance is another feature of the illness. There are, however, a large number of common characteristics which establishes the disease as an entity.

When first brought to the psychiatrist, the typical autistic child is about 5 years of age. His parents bring with them, the assumption of feeble-mindedness or auditory impairment. The most frequently used words that the parents use to describe their child are "self-sufficient", "like a shell", "happiest when left alone", "acting as if people weren't there," and "giving the impression of silent wisdom". The child may or may not be able to speak. There is, however, essentially no difference between the speaking child and the mute child as far as the

communicative functions of speech are concerned. The child does not use speech to communicate — he does not communicate. His abnormal relation to people prevents him from looking them in the eye or responding to their speech. What speech there is, is limited to parrotlike repetitions of words heard at one time and spoken at a much later time (delayed echolalia) in the exact same inflection as they were originally heard. To him, the meaning of a word is inflexible and can only be used in the original connotation as used when he first heard it. The child refers to himself in the third person and never in the first. What is brought before the psychiatrist, then, is an extremely self-isolated (Kanner's "aleness") child with a very limited accessibility.

Another symptom frequently noticed is the child's obsessive insistence on sameness. Any change in his environment or daily routine is met with a violent tantrum ending only with the restoration of the original situation. Often the child displays the most uncanny ability to recognize the slightest change in his environment — changes that would escape the notice of the most observant of adults.

While the retrospective description of symptoms by parents are always open to question, there are certain features in the behaviour of a child with "Kanner's syndrome" during the first year of life that are quite characteristic:

- (1) Daily routines of feeding, elimination and sleep are developed with much difficulty from birth.
- (2) The child is unresponsive to his environment although motor milestones and reflexes develop normally.
- (3) There is lack of assumption of the usual anticipatory posture preparatory to being picked up (normally present at 4 months of age).
- (4) He is "not cuddly". He does not adapt his posture to his mother's when picked up.
- (5) He is happiest when left alone.
- (6) He makes peculiar movements with his fingers at the periphery of his vision. He rocks back and forth, bangs his head and scratches the side of the crib.
- (7) He is unresponsive to most noises but may respond to a few and may dislike certain other sounds.
- (8) He is unusually quiet and good but may show inordinate screaming at times and cannot be consoled by being picked up.
- (9) He lacks appropriate responses to sensory stimuli whether visual or auditory.
- (10) Speech is delayed if it develops at all. Occasionally, it develops normally for the first couple of years and then is lost.
- (11) When breast-fed, he is a very slow sucker.

These symptoms alone are hardly enough to base a diagnosis upon, but a definite pattern can be seen in the major components of the disability. The perceptual and speech disabilities seem to present themselves as primary symptoms with affective disturbance, social withdrawal and odd behaviour as secondary features. Each of these components should be evaluated separately in planning the management and education of the child.

When older, the autistic child shows disturbances in auditory and visual perception as well as in motor behaviour. Not every child shows every symptom, but he shows a large number of them to one degree or another.

A major feature of the child's disturbed auditory perception is his avoidance of most sounds and common speech in particular. He is unreactive to loud noises but may show fascination for certain sounds like tapping sounds and echoes. He may be able to sing and have a keen interest in music even though his speech may not have developed or it may have been developed and then lost. When speech does develop, it shows many peculiarities.

Echolalia is a very characteristic feature of autistic speech — especially delayed echolalia. Words and phrases are imitated, sometimes with the very same inflection and accent as the original speaker. The child does not answer questions but he echoes them. If speech develops, "No" is used much earlier than "Yes" which may never be used. Words are frequently used in the wrong order, e.g. "Place plate on toast." There are also abnormalities in the production of words. For instance, "glub" may be said for "glove". In the more gifted autistic child, there is a preference for non-verbal language like music or mathematics. Some learn to read before they can talk. In general, however, the autistic child avoids verbal communication — he may lead an adult hand to perform some task for him rather than ask when he is capable of doing so.

The visual perception problems of the autistic child present very interesting discrepancies. While he does seem to have difficulty in recognizing things seen (he may not even recognize his own home at a distance), he is not, by any means, short-sighted or blind. One autistic boy is known to enjoy picking up and collecting minute pieces of cotton. There is a definite preference for peripheral vision to central vision. He may seem to look past objects and people and may climb stairs watching his feet and yet never tumble. He can recognize quickly moving objects. In fact, he has a fascination for moving objects. Complex visual patterns (e.g. human figure), however, are avoided.

Other sensory modalities may be involved in a number of other peculiarities commonly reported. The autistic child enjoys motion and is frequently seen spinning himself as if he derives "masturbatory gratification" from such movements. He enjoys the sound and the sensation derived from the scratching and tapping of surfaces. He

may show unusual pleasure in feeling smooth surfaces or furry materials and in the smelling of certain odours. Water holds a peculiar fascination for him.

It is the autistic pattern of motor behaviour, however, which most frequently strikes the casual observer. Most autistic children are very graceful in movement and show unusual interest in some motions, such as spinning, rocking and sliding. Peculiar movements like jumping up and down, walking on tip-toes or with a special gait (e.g. sideways), spinning around, and flapping of arms, especially when excited, are often observed. Self-stimulation through forceful head-banging, rocking, the handling of small objects and self-mutilation (e.g. biting the hand or arm) is often indulged in.

Other odd and repetitive tasks may be performed with compulsive ferocity. The autistic child may collect objects of interest like paper, lint and tin lids and will show great distress if one of them is lost or taken away. And if he can speak, he may recite long passages of poetry or bus time-tables. Tantrums with tears, stamping and kicking are common and cannot be stopped when the child is comforted but may stop for no reason at all. Inappropriate laughing and giggling (but with no hallucinations) may also be noticed. The child may express no fear for usual dangers (heights, moving cars, etc.), but may fear harmless things.

The combination of a number of the above-mentioned symptoms renders "early childhood autism" and "Kanner's syndrome" relatively easy to differentiate from blindness, deafness, primary aphasia, epilepsy, hyperkinesia and mental subnormality. The disease may, however, appear in its pure form or in a mixed form with a combination of disorders. What follows is a case presentation of what appears to be an example of the pure form.

CASE PRESENTATION

Peter, a healthy and serious looking 8 year old, was admitted to the Clarke Institute earlier this year with the chief complaint of disturbed behaviour for 4 years duration. On admission, the terms commonly used to describe him with were "irritable", "can't relate", "temper tantrums", and "clams up". He had a flat affect and wore a fixed smile on his face. He was aware of the presence of people in the room but took pains to avoid body contact.

Peter seemed to have developed normally from birth until 2 years of age. He sat up at 8 months, walked at 14 months, spoke at 2 years (single words at 18 months) and was toilet trained at 3 years. At 2 years of age, his speech development ceased and unusual behaviour patterns gradually developed.

It is not known whether he has any abnormalities of auditory perception, but Peter does seem to have a visual perception problem. Before handling objects, he would

EARLY INFANTILE AUTISM

first touch them with outstretched arms as would a partially blinded child. But there is no question of blindness — his parents report that he is able to assemble geometric puzzles and there is no suggestion of the cautious and slow movements of the visually impaired.

When first seen, Peter spoke at the 2 year old level, with approximately 25 words that were poorly developed phonetically and characterized by unusual syntax, echolalia and private meaning. His only distinctly clear words were “candy” and “pickles” presumably his favorite foods. “Go see mommy” was, and still is, a common repetition of his.

Peter has good motor coordination, being capable of climbing cupboards without difficulty. He can manipulate small objects with considerable skill and is forever involved in some kind of activity or other.

In the field of unusual behaviour, he has a tendency to engage in repetitive activities unless he is actively stopped. Frequently, he grasps both hands together and forcefully swings them from side to side. He occasionally has temper tantrums for no known reasons, with kicking, stamping and the banging of his head on a hard surface. On these occasions, he has also been noticed to bite his hands with no indication of pain, although a puzzled expression may be assumed. When walking, he may suddenly crash to the floor upon his knees. In his constant hyperactivity, Peter has a penchant for climbing, removing his shoes and socks, and spinning objects and himself. He has been known to spin himself until he fell with dizziness. Peter has an unnatural fear for wrinkles observed on table cloths and for crowds of people. On the other hand, he has no fear of traffic. Running water has a peculiar fascination for him.

PREVALENCE AND IMPLICATIONS

Estimates of the prevalence rate for “early infantile autism” range from about 4 to 10 per 10,000. This great variation in the estimates can be attributed to the fact that researchers use selection criteria that are rarely stated in such a manner as to permit useful comparison. There is a complete lack of agreement on the behaviour criteria to be used. The general lack of adequate behaviour descriptions is illustrated by the fact that those of Leo Kanner are still, by far, the most detailed — and they are over 20 years old. The behavioural criteria of Creak, however, are the most comprehensive (unevenness in intellectual retardation, bizarre motility, gross anxiety reactions, unusual sensory sensitivities, etc.). And yet, her criteria were not specifically designed for the recognition of autistic children but for the recognition of psychotic children. Such is the present sad state of affairs.

There is, at present, no reported intensive study of the prevalence of this disorder in children. V. Lotter (1966) has, however, done a reasonably thorough screening of the entire 8-10 year old population of the County of Middlesex, England, to identify children with autistic behav-

iour. Using behavioural criteria, he got a prevalence of 4.5 per 10,000. Thus, of the 379,000 5-14 year olds in Middlesex, 126 were autistic. A comparison with other handicaps showed 57 blind children and 175 deaf children, all of whom were found in special schools. Lotter reported a boy-girl ratio of 2.6 to 1 (vs. Kanner and Creak's boy-girl ratio of 4 to 1). In the entire population of England and Wales, then, there are 3,000 autistic children of school age and 2,000 below school age. Of these, 700 are in mental subnormality hospitals. In comparison, there are 1,400 blind children and 3,500 deaf children, all of whom are in special schools. There are virtually no special schools for autistic children.

If anything, these figures point to the fact that as compared with other varieties of handicaps, autism is a fairly sizable problem. The Secretary of State of Britain has 10 categories of handicap requiring special education facilities — autism is not one of them. Therefore, there is a strong case for the establishment of special schools for autistic children.

SUMMARY

A short review of the symptoms to be found in “early infantile autism” was presented along with a “typical” case history. The major features of which are:

- (1) Lack of demonstrable feeling towards people.
- (2) Lack of interest in the outside world.
- (3) Preoccupation with repetitive tasks.
- (4) Slowness in learning to talk or absence of speech altogether.
- (5) Obsession with the maintenance of sameness.
- (6) Bizarre behaviour and perceptual patterns.

Mention was also made of the need to differentiate the condition from deafness, primary aphasia, and primary mental subnormality.

A very brief discussion of the prevalence of the condition was presented as well as the implications.

ACKNOWLEDGEMENTS

I would like to thank Dr. M. I. Gokcen of the Clarke Institute for his help and advice in the preparation of this article. I also thank Dr. Helen Connell of the Royal Brisbane Hospital, Brisbane, Australia, for introducing me to the subject of “early infantile autism”.

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A CRITICAL REVIEW

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The 1927 Class At The University Of Toronto

One questions the wisdom of raking up the dead leaves of a dead past. The questionable reward to be gained by one who does so can be not only disillusionment but considerable pain inflicted on oneself. But is this necessarily true in science? Here the harvest that can be accumulated from the raking can very frequently lead to a much greater understanding of the present, which in turn can point the way to substantial progress for the future. There is however, one cardinal condition that has to be met before one can dare put the findings of the review down for all to read in detail — and that condition is that it must be based on complete honesty. The words must be recorded with an unbiased candor, and lastly there must be no deliberate malice toward anyone. Otherwise it merely degenerates into a vendetta against the events of the past as well as its participants of that era. I am prepared to meet the conditions I have laid down, and make them subject to the scrutiny of anyone. Nor do I undertake the making of this to be based solely on my own scientific analysis. Many indeed are the informal discussions that I have had with my former classmates whose findings, in the main, are identical with mine, and who lived through the medical years that culminated in our graduation at the University of Toronto forty years ago. This is the year of the ruby jubilee for the class. This is also the year for contemplation and summation.

In a forty year span in medical education it would be unreasonable for one not to expect great changes in teaching to have taken place. The curriculum would surely have had to undergo a moderate amount of evolution as subjects change in importance on the medical scale. Viewpoints, once held as scientifically valid and defended with great vigor, bend and then disappear with the passing years. Also methods of teaching change with the newer times. All this is quite natural. A synopsis of the variations when thoroughly scrutinized can however be quite revealing. The class that met shortly after the triumphant conclusion of the so-called First World War, a war that was fought in the filth and agony of trenches, a war in which the propagandists unashamedly smothered us with the lie that this was a war to end all wars, in which the pillars of democracy were to be preserved, and in which Kaiser Wilhelm was the "bête noir" of the world, was assuredly strikingly different from those now entering the 1967 class. This new class has the grim spectre of atom bombs raining down on their heads, which in turn has led to their having a greater sense of frustration intermingled with a great deal of confused thinking. Our era, bathed as it was in idiotic fantasy, has given way to the modern student who has judged for himself how little we of the past gained from our idle dreams, and, as a result, has

turned the other way, and become much more realistic than what we were at all levels of scientific approach to problems.

The keynote of our undergraduate lives during our entire six years at the University of Toronto 1921-27 was one of intense, cruel fear. The greatest emphasis at the University was in the passing of examinations. The entire six years for most was a grim-faced struggle entirely devoid of levity. *Learning, in and of itself, was a luxury that very few of us could afford — for what good was to be gained in medical learning if we were to be confronted by the goddess of examination failure under whose piercing scrutiny we were to be constantly exposed.* This incessant fear was not one that was conceived solely in our imagination. It was born within us from the very first day of our entry into the medical college. There we were met by the Dean of the faculty of medicine. He was grim-visaged, hard in demeanor. *This post-war class was far too large,* he informed us, for proper teaching purposes. *One third of this group would be flunked by the end of the academic year,* were the words he uttered. Work hard, show your quality, or you would meet the fate meted out by the *overhanging medical axe.* There was the startling image of things to come thrown at this group forty years ago. For a third, the year was already ordained to end in tragedy. The year of work, the year of sacrifice, the year of hope would end for naught for those already doomed. Nothing was to be ever said of the scar it would leave in the soul of those that were to be so rudely cut off. What criteria the faculty was to use in separating the so-called unworthy student from the worthy one remained forever a "gestapo secret". An excellent student of this first year class whom I knew personally was flunked out at the end of the first year. Amazedly he appeared at the medical office for an explanation for what they had considered to be his failure to meet the requirements. He was informed he had been dismissed not because of poor grades but because the faculty had discovered he was color blind! How could he do adequate work in bacteriology, they said, if he were color blind?

Quizzes, examinations, surveys were constant throughout the entire medical course. Every clinic was conducted on an examination basis. Every practical demonstration began and ended on a quiz basis. *This is not to infer that examinations are not necessary in the course of a career of medical studies. However today's students revolve in a far freer scientific environment with the emphasis on learning, not on daily quizzes. True, they must meet minimum requirements as laid down by proper medical authorities. But fortunately medical Hitlerism in medical universities such as we endured has long ago disappeared.*

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An even greater change has taken place in the last forty years in the degree and quality of *rapport between students and the medical faculty*. All the classmates of my class are almost as one in describing that era as being *utterly devoid of any medical rapport*. The faculty lived and taught from a cloud high in the stratosphere. The student was a lowly creature and had to learn whatever and whenever he could by the method of hard knocks. The lowliest demonstrator, having finally succeeded in reaching his ozone post on the medical faculty, was an overseer who felt empowered to wield a hidden "whip". Lectures were given from a high pulpit as intellectual bread crumbs to be tossed to the disenfranchised. Classes were prolonged quiz sessions. And in the main with some notable exceptions, quiz sessions were merely one or two hours of waiting around by the students while one particular class member was given a boring, third degree which left both the teacher and the student limp at its conclusion. Each knew that his turn would surely come at a future date.

All these happenings more or less now belong to a distant past. The degree of interplay between teacher and student is now infinitely closer, and much more cordial with a greater mutual understanding. Its ultimate effects are more satisfying and the degree of medical learning by the undergraduate is significantly fuller than in our era.

The classes of 1927 had been sternly told from the earliest possible moment that there would be no semblance in their teaching of what they termed, "spoon-feeding". How many times over and over again were we to hear the term spoon-feeding used in a degrading manner. Spoon-feeding was for kindergarten children, not for grown mature men seeking a medical education. Spoon-feeding would not be tolerated by the faculty, would not be indulged in at any time or place. And what did they propose to displace spoon-feeding with? We were soon to find out.

What sins are constantly being committed by those who are experts in semantics, I leave for the intelligentia to decipher and record. Here, in those days, was a *modus operandi* practised by an advanced medical professorship that imparted the barest minimum of information to the students, but relied instead on a system whereby most, if indeed not all of the data of scientific study, would have to be dug up by the student himself. How far this method of a denial of spoon-feeding was carried out can best be illustrated by an amazing example that occurred during my early undergraduate days. At the first clinic in physical diagnosis in medicine at the Toronto General Hospital we met our teaching professor on the ward. We had never previous to this encounter been on the ward of a hospital. We were extremely exhilarated during that long forgotten morning on the hospital ward, at having reached this high plateau in clinical medicine. This professor's task at the opening session was to introduce us to the course

in physical diagnosis. His demeanor, as he faced us, was as hard as the cement floor of the hospital ward. His moustache bristled as he spoke. As a first assignment he ordered us to examine the eyes of the patient in a neighbouring bed and then to point out to him what was physically abnormal in that organ. None of us had ever been in any previous contact with a patient. We had never received any form of lectures or indeed any form of guidance in physical diagnosis. And as for the human eye — at no time had we ever spent any time or study anatomically, physiologically, or clinically in that field. We trooped singly before the patient and went through the motions of examining this patient's eyes. Then he blustered angrily at us as we gave him little or nothing in the way of findings. We stood silent and erect as wooden soldiers as he stormed on. We were an unobserving group that knew nothing and saw nothing, he said. How could we miss what was so obvious for even the dullest fool to see. He finally ended his lengthy harangue as the tortuous session came to a merciful end by giving us the physical diagnosis. The patient had arcus senilis of the eyes. How simple! Then he abruptly left. At no time did he demonstrate his diagnosis. Nor did we then know what he was talking about, either as to physical findings or diagnosis. This, then, was our introduction that we had to the era that revelled in spurning "spoon-feedings."

Clinical groups that were conducted about a patient's bed forty years ago were in the main, "raking" sessions. A student would be asked regarding his findings. Then the tormenting session began while the other members of the group stood by in rigid silence. Each knew that his turn would come at a future date. I still cannot remember an iota of knowledge that we gained from those "gestapo" sessions. Little or nothing was ever demonstrated.

This triad of 1927 — of *exacting harshness, of total lack of rapport between professor and student, and the peculiar philosophy of total denial of what they termed "spoon-feeding"* — a triad that has since disappeared — were all minor issues as compared to the one striking change that has now taken place. This change is an extremely significant one, embodying an entirely different approach to undergraduate teaching in medicine.

One of the Mayo brothers visited the University of Toronto in 1927, and when subsequently interviewed shortly thereafter, stated that many of the leading medical universities were graduating medical scientists but not practising physicians. This was an extremely important pronouncement, and was voiced generally by many of the medical educators at that time. Unfortunately, it would be many years before any significant change actually took place to alleviate this situation.

The entire emphasis during the six year course was on the academic side of medicine. The basic sciences were stressed to a point beyond what was considered

absurd. That the basic sciences in medicine are extremely important none will deny. But as in so many phases in life, one wonders where sanity in a viewpoint begins, and when insanity finally takes over.

One remembers with mixed emotions the "pathology lab" course where countless hours of countless afternoons were spent in labelling pathology drawings. The microscopic slides were carefully sketched on drawing paper, colored, labelled. Neatness was the order of the day, in doing this work. The learning of pathology was distinctly secondary. What was true of the course in pathology lab was true of so many of the other so-called lab classes. A few demonstrators paced the aisles as we worked on these drawings. What their purpose was I never did find out as they contributed but little in the way of instruction. Instruction in all the lab courses ranged from sparse to negligible. With the class over 150 in number any or all work done by the student at that time was on a "catch-can" basis.

The academic mood that prevailed received its greatest support in the clinical years. *The practical as it pertained to the practice of clinical medicine was almost totally ignored.* The best example of this (and I have discussed this with more than a trace of amusement with several members of our class) was when in the sixth and final year, the head professor of medicine in those days spoke for month after month about only one set of diseases — blood diseases. The origin of the blood cell, the normal blood cell, the abnormal blood cell, etc. As the weary weeks went into months we all wondered whether humanity had ever fallen victim to any other disease but the one under this constant discussion. The rationale to this approach to medicine was that if you were thoroughly taught just a single disease in this manner, you would learn the proper method of approach to all diseases, and you could study them later yourself out of text books, or as you met them in actual clinical experience. To enumerate the other diseases of mankind let alone go into them in any detail would again be spoon-feeding. Singularly absurd yes — but true, nevertheless.

An appearance by an undergraduate student in an operating room while not forbidden was distinctly frowned upon. *All the practical aspects of medicine were avoided where humanly possible.* While this was not followed to the letter in clinical surgery, it was definitely true in clinical medicine. *The viewpoint was that one would learn all this later in an internship or in actual practice. To compound absurdity a degree further, internship was not compulsory nor indeed was it encouraged.* Upon the slim framework of this academic training we were given a diploma signifying our readiness to treat with great practicality the various diseases of mankind. After all, had we not been thoroughly prepared to do so, now that we had been the recipients of a four month lecture tour by the professor of medicine on blood diseases.

The so-called "specialty" studies were not included in the general medical curriculum forty years ago except in a most insignificant manner. A few pathetic lectures and clinics were given in otolaryngology and ophthalmology. An attempt was made to teach the barest of the fundamentals in these courses — but they were doomed to failure by the degree of de-emphasis that had been placed on them by the faculty — a de-emphasis that the undergraduate students quickly took advantage of by both their disinterest and lack of attendance. This failure to teach the specialties adequately would show up in the later years of clinical practice. For a great many the ophthalmoscope would remain forever an instrument of mystery. We would also retain very little more than a layman's approach to refractions and the part they played in health. Many other examples could be given, if one cared to enumerate them. All this would be remedied by a later generation.

Our greatest medical vacuum was to be found in our utter lack of understanding in the specialty psychiatry. True, it was a new science at the time and but poorly understood by a large portion of the faculty themselves. This tremendous specialty, problems in which we were to meet daily in our practice, was utterly ignored. The emphasis in this era was on neurology. Now the order is reversed and justifiably so. In this specialty, as in all others, it was felt that the medical practitioner should refer at once all those patients to those better qualified to treat them. However, with so poor a background in these specialties, we were in a faulty position to be able to properly sort out these problem cases even on a referral basis.

The changes in medical outlook that have taken place have been very great. The newer graduate is better trained, better qualified. He is in a better position to meet the challenge that medicine offers upon his graduation. All is for the better and mercifully so.

A word must be written in closing this era of four decades ago about the changes that have occurred in the faculty and students themselves. To disregard this change would be to pass over a truly vast revolution that has occurred. This change has occurred not only in the medical universities but in all sections of college life not related to medicine. In the American universities this change has become so great as to involve great changes in the political structure of the university itself. I refer specifically to the change in liberality that has occurred. The rock-bound conservative approach, while still present, is in the minority. To this minority of the faculty and the students, this change then has been a change for the worse, a change that they abhor. But to the greater majority of the faculty and students, this previous viewpoint was not only cruel but inhuman. If one were given to labelling one might be justified in calling their previous viewpoints as fascist. No longer is the student afraid to voice his viewpoint. No longer is a member of the faculty fearful of presenting his ideas. No longer

is the student tortured by the thought of ready dismissal for the most minor infractions. The air of the academic life has been vitalized and the importance of the university itself has risen greatly. It is true that even forty years ago many of the professors were of liberal disposition. Men like Professor Oskar Klotz, Professor J. J. R. McCleod and others too numerous to mention were of the "salt of the earth" in every conceivable category of character. But in the older era there was a significantly large coterie of men whose viewpoints were entirely different. The female student was frowned upon by these men. The presence of women in medicine lowered the prestige of the profession, they determined. They tolerated the negro student with a minimum of forbearance. Behind the Jewish student they saw only the image of the rag-peddler's son. The picture of the

Jew that they had was of Shakespeare's Shylock or Dicken's Fagin. There were no other types of Jew to them. Let us leave this nauseating subject quickly. For those of the minority group that ran the six-year gauntlet during that era, the years that have gone by have mercifully erased everything. Let it stay erased.

This then is the scientific record of the 1927 class that graduated from a great university. The university was symbolic of the times. Everything that occurred there, occurred in most of the better universities.

EDITOR'S NOTE:

This author's very personal view of the Class of 1927 at the University of Toronto was received in June, 1969. We have not been able to publish it until now.

Dan Perlitz, 7T1

The Browndale Concept Of Child Treatment

The emotionally disturbed child presents a problem to doctors in many fields of medicine, in particular the paediatrician and general practitioner. Invariably a child's disturbance is a result of some disturbance in his family framework and cannot be divorced from this underlying origin of his personality. Yet we as a society have resorted to just such a divorce in dealing with many of our disturbed children, sending them to institutions designed to heal them in isolation from their prime parenting figures. When we see the obviously destructive influences on their family we say this is for the child's own good. When we cannot see it as clearly we somehow believe there is something "wrong" with this child, something to which his parents should not have to be subjected. So we end up sending him away to "training school", to an "Ontario hospital school" (supposedly for retarded and organically damaged children but in fact where many disturbed children end up), to a foster home, or to one of a small number of selective treatment centres for disturbed children.

The largest of these treatment centres is Browndale, a non-profit organization now treating over 200 children in Ontario, as well as many others in the rest of Canada. I had the privilege of working at Browndale for several summers and one whole year as a house-head with 4 disturbed children and one other staff in a suburban home in Cooksville. Below is an excerpt from a speech I gave in 1969 at the Menninger Institute outlining the basic plan of treatment at Browndale.

Although the Browndale programme is excellent in my opinion, there is no doubt that the future for treating disturbed children lies first in the prevention of such disorders and secondly in treating the entire family, not

the isolated child who is merely the symptom of the disease. There is also no doubt, unfortunately, that there will be a continuing need for treatment centres such as Browndale for a hopefully ever decreasing number of children who simply cannot be helped in their primary family. Perhaps the following may serve to inform a few of the present and future doctors of this province about a programme that in spite of its tremendous success enjoys an unmatched degree of disfavour and suspicion within Ontario's medical profession.

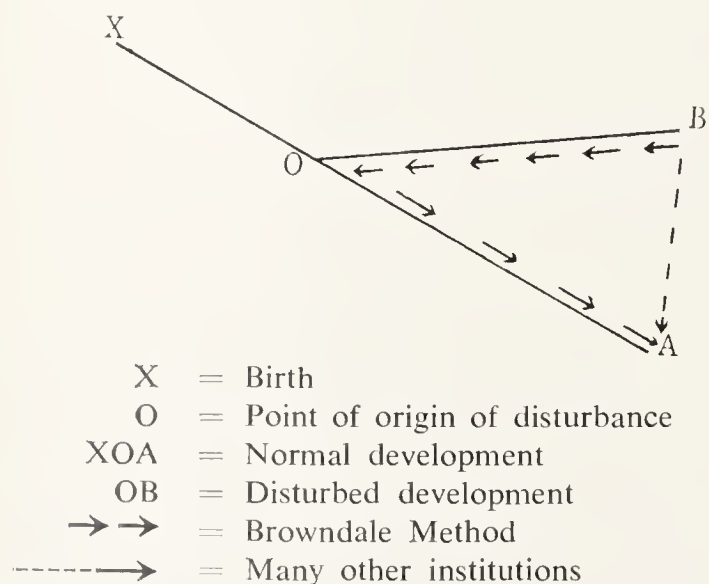
Basic Plan of Treatment for Each Child

The disturbed child comes to us with a set of symptoms that are an outcome of the best possible way that he can cope with his life experience. We do not right away attempt to take away his symptoms unless they are injurious to himself or others. Rather, we let the child know that we accept his symptoms, and understand that they are as necessary to him as our own healthy defence mechanisms are necessary to us. I would like to give you an example.

Several years ago, a young 12-year-old girl, let us call her Margie, came to us for treatment. She was a very sick youngster who had been diagnosed by a referring physician as a childhood schizophrenic. Her behaviour was bizarre and her symptoms many. One of these symptoms was that she would repeat endlessly a demand which she was making. This would usually be done at the top of her voice and with many different tones of voice and pitches. Thus, I might walk into the house and find her at the top of the stairs with her hair going in all directions, with a brush in her hand, and screaming away at the top of her voice, "Brush my hair, brush my hair, . . . brush my hair, brush my hair, . . ." and

would repeat this endlessly. Now, my own reaction to this would have been to say to her, "Look, why are you standing there at the top of the stairs screaming away like that? Somebody will be glad to brush your hair for you but we are all in a meeting right now and you can see that. And anyway you can brush your hair yourself, you are an old enough girl to do that. So stop screaming and somebody will come and brush your hair very soon. There is no need for you to be carrying on like that." However, if Margie could have verbalized her feelings she might have said something like this: "Sometimes I get so very anxious when I feel I need something done, I feel like I am going to die if I don't get that thing. Nobody has ever helped me when I get to feel this way, and the only thing that helps me at all is if I can scream at the top of my voice over and over again what I want done and then maybe I can shut out that other feeling a little bit." Thus, we tried to understand Margie in her need for such control mechanisms as screaming at the top of her lungs over and over again. We begin by accepting the child for what she is.

What happens next is that in an atmosphere of acceptance and being well cared for physically (which in itself is very important) the child is allowed and encouraged to retrogress to the level of functioning which he is most comfortable with. There is a simple diagram which John Brown has used to demonstrate this:



The problem is how to bridge the gap from B to A. Most children's institutions in Ontario have tried to do this by a shortcut from B to A, (see diagram) using a system of reward and punishment to obtain normal behaviour from the children. It works; the children learn to cope with the institution they are in and as long as the bridge is supported by the rewards and punishment it is maintained. Once they leave the institution, however, they are not flexible people able to cope with the many and varied problems that life presents unless by some chance they were able to form a relationship with an adult at the institution, such that they were able to internalize some of his life style, i.e. his ego strength. Otherwise the bridge collapses; the child reverts to his

disturbed stance in life which in fact is all that he is really capable of with his own inner strength. This may be one important reason for the high recurrence rate of crime among Ontario Reformatory inmates. At Browndale we say that we have to allow the child to go back to the point O, the original starting point of his disturbance and then go on from there in the context of a relationship that satisfies his needs and allows him to grow naturally. A child is then prepared for the stresses and strains of life.

One important fact which I should mention is that few of our children retrogress in all areas of life. Rather, they do so only in those areas wherein they have great, unmet needs.

Of course, the diagram is only a hypothesis, but again and again we have seen that it works. The example of a child with whom I worked that I will give at the end of this section is a case in point.

What I found is that our younger children could allow themselves to retrogress much more easily than the older adolescents for whom it could be quite threatening; a tough 15-year-old teenager who has had to adopt a delinquent pattern in order to survive has a hard time admitting to the great young-child needs he has and allowing himself to be cared for as a young child, which emotionally he really is in many ways. This 15-year-old delinquent who has had to fend for himself for a long time may want very much to be dependent and to be cared for but at the same time may find this very threatening. He usually presents us with opportunities, however, to minister to these needs in a way that does not force him to acknowledge to himself or others that yes, he would very much like to be a dependent child in some ways. Thus, he might find sitting on my knee, having me cuddle him, having me bathe him too threatening whereas a 10-year-old could accept these things readily after awhile. But a 15-year-old might not find too threatening my laying out his clothes in the morning; my bathing, cuddling, and feeding his pet with which he identifies; my giving him a lot of physical contact in a wrestle.

Thus, to sum up the first stage of treatment, we begin with a child by accepting his symptoms as necessary adaptive mechanisms. We then allow the child to go back to the level of functioning he is most comfortable at and meet the yet unfulfilled needs of earlier years that the child carries with him. We believe the child can only do this in a relationship with an adult.

The next stage of treatment involves helping the child to grow from point O (see diagram) but this time along a healthy line of development to point A. We introduce some new elements in our relationship with him: for one thing, we make him gradually more and more accountable for himself and for his conduct, i.e. we ask him more and more "how come" questions. Thus, we gradually accept fewer and fewer of his symptoms and

THE BROWDALE CONCEPT OF CHILD TREATMENT

expect him more and more to work out problems in a healthy way. For example, the young girl Margie that I described before developed a close relationship with one female staff, let us call this staff Sharon. After a time Sharon would no longer accept Margie's screaming over and over again "Brush my hair, brush my hair, . . . etc." She would confront her with this, ask her "How come you have to do this?" Where this would have been unfair when Margie first came because Sharon would not have been able to provide anything as a substitute for Margie's pathological defenses now she can offer Margie the strengths of their relationship, a chance to express her anxiety directly to Sharon, and to receive the assurances she wants.

At the same time that we begin to make the child accountable we also begin to make the child responsible for a greater share of his normal life tasks. We begin to expect the child to do such things as take care of his own clothes, wash himself, help out with the housework, go to school, etc. We do this gradually, trying as much as possible to avoid rushing the child so that he does not fail at these tasks and meet further frustration. His ego growth will advance more surely and with fewer setbacks if he can begin to succeed instead of fail as he has before. Again, it would have been unfair to Margie when she first came to expect her to take on the responsibilities of a normal 12-year-old because she did not have the resources of a normal 12-year-old. But now, with a period of some of her unfulfilled needs being met behind her, and with a close relationship with Sharon, she can begin to take on some of these responsibilities and as she succeeds she can meet life's problems on her own. At this point I would like to share with you the development of a young boy with whom I worked closely for a year. I think his story illustrates well the principles I have been talking about.

Let us call this young boy Randy. Randy was seven years old when he came, a very anxious, frightened little boy. He grew terrified at unpredictable times, would scream hysterically as if he was about to be destroyed, was very hard to control, and was often obnoxious. He seemed quite cut off from being able to receive any security or warmth from the people around him even though he obviously needed it so much. His parents had been very punitive, harsh, and demanding, doing such things as making him take care of his younger brothers who were four and three when he was only six and making him do the beds each day. He grew gradually less anxious as he was with us and especially as he formed a relationship with one particular female staff, let us call her Lillian. Lillian mothered Randy a great deal, taking good care of his bodily needs, being very sensitive and warm to him, bottle feeding him at one point for several months during their relationship, and he became very dependent on her. In the context of this relationship he retrogressed in many

areas that he had problems with and in which he had been deprived. During the day he went to the Browdale School where he mostly finger painted and worked in clay. After this first year of treatment he went to camp for the summer and for the first time he began to relate to a male, starting to do such things as fishing, building, and other masculine activities. At the same time he continued his relationship with Lillian.

Then after camp he came to my house as we had decided that he was ready to go to school and to function in a normal suburban home. Shortly after I brought the children down from camp we had a meeting in my house regarding the duties each child would have in weekly clean-up. The previous year nothing had been expected of Randy as far as cleaning up went. He had been in the retrogressive part of his treatment. But now we decided to give him an assignment and I told him that he was responsible for the bathrooms in the house. Randy was shocked when he heard this. "I won't be able to do this" or "You don't have any right to make me do such things, you should be doing these things, not me, I am too young" were the sort of statements he made. I tried to be gentle with him, to understand with him how hard it was for him to take on these responsibilities, and reassured him that I would certainly help him with it and that I felt confident that he would be able to do it. In our first weekly cleanup Randy worked for a whole 20 minutes on only the mirror in the bathroom giving it the best shine that he could. He then came out telling me that his cleanup was done and that he wanted to go outside and play. When I looked into the bathroom to check on his cleanup with him I praised him for the excellent job on the mirror and told him that I would do the rest of it for him. The next week after bringing in a chair for him so that he could do the mirror again, instead of doing the rest for him I asked him to do it with me so that we both washed out the sink, the toilet, and the tub. From week to week, with some backward steps but many leaps forward, Randy and I worked on the bathrooms gradually having Randy do more and more on his own and doing a better and better job. By the end of the year, he was doing almost the entire cleanup of the bathrooms himself but still needed me to do a small part of it. I imagine that this year he can do it all by himself.

At the same time a similar process was taking place with Randy and his schooling. He went out to the neighborhood public school in grade one and had many difficulties at the beginning of the year, especially in coming home from school. However he did better and better with school and by the end of the year was doing quite well, getting good marks, and enjoying his school a good deal.

I had picked up Randy at the beginning of his second phase of treatment. With patience and much support Randy was able to do a great deal during this time.

Grand Round Quiz: Family Practice Problems

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DIRECTIONS:

Each of the questions or incomplete statements below is followed by suggested answers or completions. Select the one which is best in each case.

- A newborn jaundiced at age 22 hours represents*
 - a normal finding
 - a problem that needs observation
 - a pediatric emergency
 - an indication for an exchange transfusion
- Syphilis and tuberculosis are most likely to be controlled by*
 - early case finding
 - prophylactic chemotherapy
 - isolation of infected persons
 - health education
- Enterobiasis is most readily diagnosed by*
 - examination of stools
 - skin testing
 - scotch-tape applied to perianal region
 - eosinophilia
 - a typical skin rash
- A 25 year old housewife, previously healthy, presents with dizziness, dyspnea, chest pain and cough. Twelve months previously she had delivered a normal child. Physical examination of the lungs is negative. The heart is overactive. P₂ is loud and narrowly split. The EKG shows signs of right ventricular enlargement but the chest x-ray indicated the heart size to be normal. Pulmonary arteries are prominent and peripheral lung fields are hyper-radiant. Treatment will probably include*
 - aminophyllin
 - heparin
 - digitalis
 - corticosteroids
 - venesection
- A 50-year-old man with a 5-year history of a chronic, productive cough enters the hospital with typical physical, x-ray and laboratory findings of pneumococcal lobar pneumonia. Within 48 hours after initiation of penicillin therapy (600,000 units q 6 hours) his temperature was normal but on the fourth day his temperature spiked to 102°F. Physical examination and chest xray showed no change from the time of admission. The next step in the management of this patient would be*
 - discontinue penicillin and institute ampicillin 0.5 gm q.i.d.
 - discontinue penicillin and institute keflin
 - increase the dose of penicillin to 1,200,000 units q 4 hours and add streptomycin 1.0 gm daily
 - do further bacteriological studies
 - bronchoscopy

- The Tine Test is utilized in*
 - tuberculin testing
 - scarlet fever
 - measles
 - coeliac disease
 - cystic fibrosis
- A child found to be mberculin positive with no evidence of tuberculosis is best*
 - treated with chemotherapy
 - left alone and watched
 - ignored and the mother told not to worry
 - admitted to an institution
- A 30-year-old woman with meningitis and bilateral sixth cranial nerve palsy has the following findings. Spinal fluid: cell count 450 (polys 40%, lymphocytes 60%), protein 115 mg %, sugar 45 mg % (blood sugar 150 mg %), chloride 118 mEq/L, gram and acid-fast stains negative. The most likely diagnosis is*
 - viral meningitis
 - pneumococcal meningitis
 - tuberculous meningitis
 - syphilitic meningitis
 - vasculitis involving the meninges
- A newborn infant has an obvious clubfoot deformity which you detect in the nursery on the first day of life. The child's mother wishes your advice. Which of the following would you recommend?*
 - physical therapist will see the child and stretch the foot out of this position
 - orthopedic consultation is indicated and should be done by at least age three months
 - spontaneous correction is likely and this should be watched for
 - orthopedic consultation should be obtained within a few days because corrective measures are much more successful in the pliable newborn foot than at any later date
 - protective foot gear should be prescribed

DIRECTIONS:

Each of the following questions or incomplete statements is followed by four suggested answers or completions, one or more of which may be correct. Select the correct answer(s) in each case.

- Co-ordinated home care can*
 - release hospital beds
 - establish a community resource
 - provide medical care for the homebound
 - complement family physician

GRAND ROUND QUIZ: FAMILY PRACTICE PROBLEMS

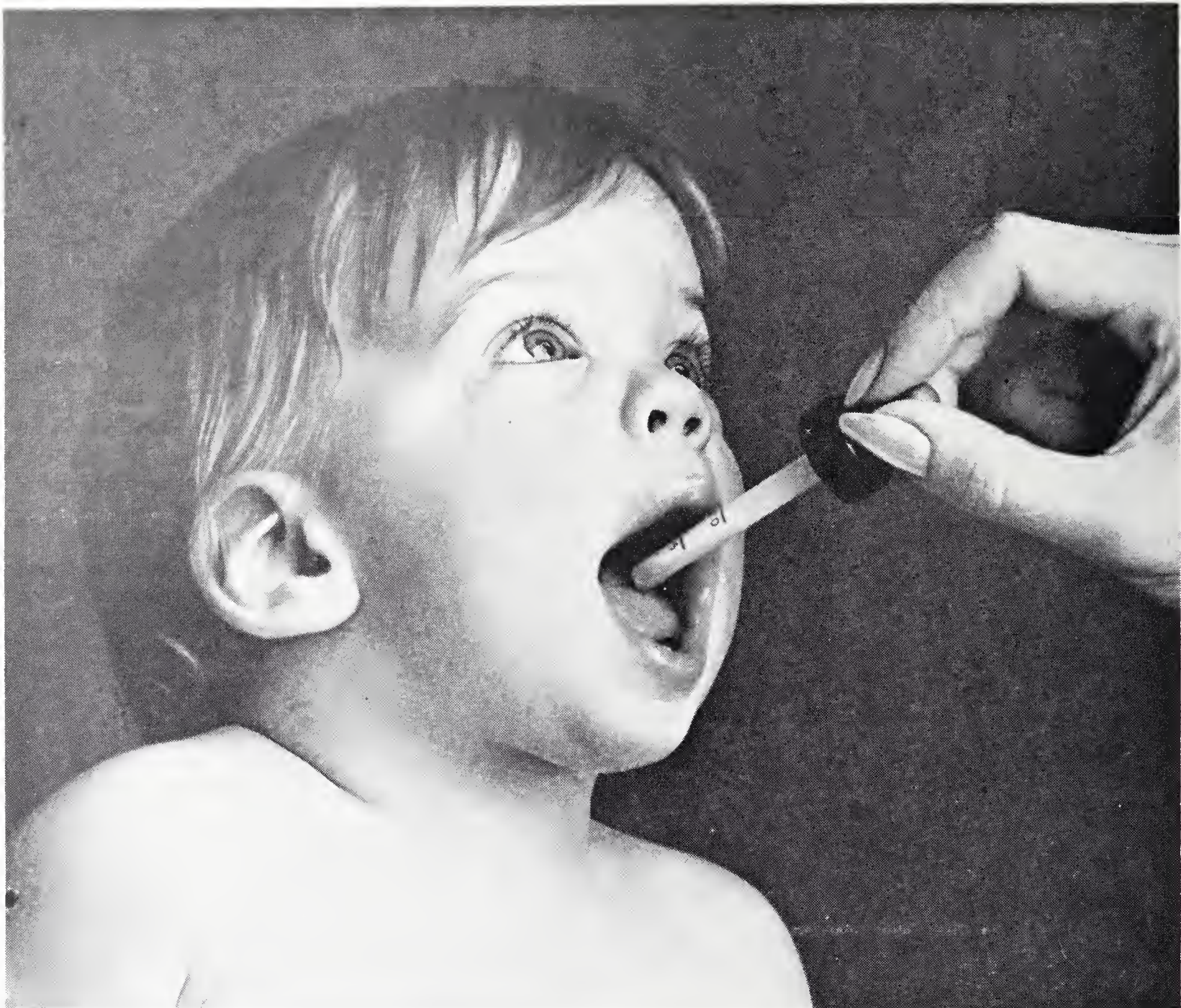
11. *In general, it is advisable that the unilateral above knee amputee be provided with a prosthesis because*
 - a. the energy requirements are less for ambulation with a prosthesis than with crutches alone, after achievement of skills
 - b. sedentary skills are improved
 - c. in the instance of arterial insufficiency the remaining lower extremity is less traumatized during ambulation
 - d. cardiac function is improved
 12. *In streptococcal infection of a newborn infant, tetracycline should not be used because:*
 - a. may cause permanent discoloration of the infant's teeth
 - b. is not available in liquid form
 - c. has no effect on streptococci
 - d. many streptococci are resistant to tetracycline
 13. *The Rubella syndrome in the newborn is characterized by*
 - a. thrombocytopenic purpura
 - b. congenital heart disease
 - c. hepatomegaly
 - d. cataracts
 14. *Adhesion of the labia minora in childhood*
 - a. are best left alone
 - b. should, if extensive, be separated surgically
 - c. are common
 - d. should usually be gently separated and topical estrogens applied
- DIRECTIONS:**
Each of the following questions or incomplete statements is followed by suggested answers or completions. Select the one that is best in each case.
15. *Anovulatory cycles in an adolescent female are characterized by*
 - a. dysmenorrhea
 - b. menorrhagia
 - c. shorter cycles
 - d. amenorrhea
 16. *It might prove very harmful to administer digitalis in which of the following conditions?*
 - a. atrial fibrillation
 - b. atrial flutter
 - c. cor pulmonale
 - d. ventricular tachycardia
 - e. hypertensive heart disease with failure

ANSWERS

1. c This is a pediatric emergency since 95% of the time jaundice represents erythroblastosis but may not require exchange.
2. a In controlling the spread of tuberculosis and syphilis, the early finding and treatment of cases is the most useful single method. The others are also important.
3. c The pin worm (*Oxyuris*) emerges from the rectum at night and deposits eggs in the perianal region. Scotch-tape applied this area will pick up the eggs that might be present, and then can be easily visualized with the microscope. Examination of stools rarely reveals the eggs.
4. b The diagnosis of pulmonary embolism should be apparent and this is a clear indication for anticoagulant therapy.
5. d Superinfection has occurred with an organism that is resistant to penicillin. It is therefore necessary to identify the organism and determine its sensitivity to other antibiotics. The other procedures can predispose towards gram negative septicemia.
6. a The Tine (or prong) is coated with old Tuberculin. As the Tines are pressed into the skin, they leave behind old tuberculin. This is equivalent to performing a Mantoux Test 1-1000. These Tines have a long life, can be carried in a medical bag, avoid the use of a syringe and the procedure is relatively painless.
7. a Most authorities of tuberculosis agree that a child with a positive tuberculin test is more likely to develop disseminated tuberculosis than a child with a negative reaction. A positive tuberculin reaction in a child with no clinical or radiological evidence of tuberculosis requires that he be put on chemotherapy for 1 year.
8. c The clinical findings suggest tuberculous meningitis, but the low chloride (normal 120-130 mEq/L) is the tip off.
9. d The management of club foot deformity is much simpler in the first few days of life than at days or weeks later. All practicing physicians, surgeons, pediatricians, and orthopedists should be aware of this point and should direct their energy to the management of this problem in the early days and even hours following birth.
10. All A home care program, by providing medical care of a continuous and comprehensive nature in the home of the patient, can achieve all the objectives listed.
11. a, c Carefully conceived and executed studies have demonstrated the reduced energy requirements in ambulation of the amputee trained in the use of a prosthesis when compared with ambulation with crutches. The remaining limb shares weight bearing with the prosthetic lower extremity.
12. a, d Tetracycline should not be used in infancy because it may cause permanent discoloration of the teeth. According to various reports about 20% of Beta Hemolytic streptococci Group A are resistant to Tetracycline. Penicillin is by far the best antibiotic for Beta Hemolytic streptococcal infection.
13. All The recent epidemic indicated all of these findings.
14. b, c No explanation required.
15. b Dysmenorrhea is not characteristically seen with anovulatory cycles.
16. d The possibility of converting the tachycardia to ventricular fibrillation is the danger here.

REFERENCE

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